New Jersey Department of Health and Senior Services

HEMOLYTIC UREMIC SYNDROME (POSTDIARRHEAL) REPORT

Date	CDRS ID No.

Name (Last)	(First)	(MI)	Sex	Date of Birth (Age)

Street Address	County

City	State	Zip Code	Telephone Number

Race	Ethnicity
☐ White ☐ American Indian ☐ Unknown/Other ☐ Black ☐ Asian	☐ Hispanic ☐ Unknown ☐ Non-Hispanic

Reporting Physician (Name, Address and Telephone No.)	Hospital (Name, Address and Telephone No.)

Date of Diagnosis	**Onset Date of Illness**	**Hospitalized-Date of Admission:**	**Deceased?**	Case Status
____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	☐ Yes ☐ No ☐ Unknown	☐ Possible ☐ Probable ☐ Confirmed

Clinical Manifestations:

1. Anemia: ☐ Yes ☐ No
2. Renal injury: ☐ Yes ☐ No
3. History of acute gastrointestinal illness within the last 3 weeks (ask specifically about E. coli O157:H7 or Shigella dysenteriae infections): ☐ Yes ☐ No

   If Yes, specify: _____

Laboratory Test Results (Attach copy of lab reports)

1. Hemoglobine: _____
2. Microangiopathic changes (schistocytes, burr cells or helmet cells) on peripheral blood smear present:: ☐ Yes ☐ No
3. Creatinine: _____ BUN: _____
4. Hematuria: ☐ Yes ☐ No Proteinuria: ☐ Yes ☐ No
5. Stool bacteriological examination: _____ ☐ Not done

Comments:

Name and Title of Person Submitting Report	Telephone Number

CDS-15
APR 03